		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025098

Facility Name: FREEBURG CARE CENTER

Address: 746 URBANNA DRIVE (Number) FREEBURG (City) 62243 (Zip Code)

County: ST. CLAIR

Telephone Number: (618)539-5856 **Fax #** (618)539-3412

IDPA ID Number: 371062186001

Date of Initial License for Current Owners: 03/14/79

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROGER BAGLEY **Telephone Number:** (618)549-8331
JAMESTOWN MANAGEMENT

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____ (Date)
	(Type or Print Name) ROGER W. BAGLEY
	(Title) CONTROLLER
Paid Preparer	(Signed) _____ (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	93	Skilled (SNF)	93	34,038	1
2		Skilled Pediatric (SNF/PED)			2
3	25	Intermediate (ICF)	25	9,150	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,188	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	876	10,401	1,788	13,065	8
9	SNF/PED					9
10	ICF	15,836	2,607		18,443	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,712	13,008	1,788	31,508	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.96%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/16/79

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/16/79 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1,788

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	146,839	7,882	7,187	161,908		161,908		161,908			1
2	Food Purchase		105,571		105,571	4,811	110,382	(763)	109,619			2
3	Housekeeping	84,409	10,624		95,033		95,033		95,033			3
4	Laundry	49,378	9,693		59,071		59,071		59,071			4
5	Heat and Other Utilities			81,978	81,978		81,978		81,978			5
6	Maintenance	28,718	15,574	28,220	72,512		72,512	1,253	73,765			6
7	Other (specify):*											7
8	**TOTAL General Services**	309,344	149,344	117,385	576,073	4,811	580,884	490	581,374			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,141,126	22,117	273,260	1,436,503	(5,320)	1,431,183		1,431,183			10
10a	Therapy	1,762		552	2,314		2,314		2,314			10a
11	Activities	33,066	2,684	1,340	37,090		37,090		37,090			11
12	Social Services	25,909		1,340	27,249		27,249		27,249			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,201,863	24,801	279,492	1,506,156	(5,320)	1,500,836		1,500,836			16
	C. General Administration											
17	Administrative	62,570		6,600	69,170		69,170		69,170			17
18	Directors Fees			5,200	5,200		5,200		5,200			18
19	Professional Services			118,632	118,632		118,632		118,632			19
20	Dues, Fees, Subscriptions & Promotions			7,820	7,820		7,820	(3,175)	4,645			20
21	Clerical & General Office Expenses	48,200	7,825	12,672	68,697		68,697	687	69,384			21
22	Employee Benefits & Payroll Taxes			273,499	273,499	509	274,008		274,008			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,989	2,989		2,989		2,989			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			50,578	50,578		50,578		50,578			26
27	Other (specify):*											27
28	**TOTAL General Administration**	110,770	7,825	477,990	596,585	509	597,094	(2,488)	594,606			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,621,977	181,970	874,867	2,678,814		2,678,814	(1,998)	2,676,816			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number FREEBURG CARE CENTER #0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			29,693	29,693		29,693	59,274	88,967			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,487	15,487		15,487	8,590	24,077			32
33	Real Estate Taxes			42,976	42,976		42,976		42,976			33
34	Rent-Facility & Grounds			132,000	132,000		132,000	(132,000)				34
35	Rent-Equipment & Vehicles			38	38		38		38			35
36	Other (specify):*											36
37	**TOTAL Ownership**			220,194	220,194		220,194	(64,136)	156,058			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		118,007	78,521	196,528		196,528		196,528			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,782	64,782		64,782		64,782			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		118,007	143,303	261,310		261,310		261,310			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,621,977	299,977	1,238,364	3,160,318		3,160,318	(66,134)	3,094,184			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	25,613	30		9
10	Interest and Other Investment Income	(103)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(763)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(251)	21		18
19	Entertainment				19
20	Contributions	(535)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(3,150)	20		28
29	Other-Attach Schedule	(12,547)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 8,264		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(74,398)	SCHVII	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (74,398)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (66,134)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

FREEBURG CARE CENTER

ID# 0025098

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	LINE 29 DETAIL OF OTHER ADJUSTMENTS	$		1
2				2
3	CHAMBER OF COMMERCE DUES	(25)	20	3
4	ADJUSTMENT FOR DEFERRED PAINT XIX-H	1,253	6	4
5	INTEREST PAID TO OWNERS ON LOAN	(13,775)	32	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(12,547)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(763)	0	0	0	0	0	0	0	0	0	0	(763)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,253	0	0	0	0	0	0	0	0	0	0	1,253	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	490	0	0	0	0	0	0	0	0	0	0	490	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,175)	0	0	0	0	0	0	0	0	0	0	(3,175)	20
21	Clerical & General Office Expenses	(786)	1,473	0	0	0	0	0	0	0	0	0	687	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(3,961)	1,473	0	0	0	0	0	0	0	0	0	(2,488)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,471)	1,473	0	0	0	0	0	0	0	0	0	(1,998)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	25,613	33,661	0	0	0	0	0	0	0	0	0	59,274	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,878)	22,468	0	0	0	0	0	0	0	0	0	8,590	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(132,000)	0	0	0	0	0	0	0	0	0	(132,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	11,735	(75,871)	0	0	0	0	0	0	0	0	0	(64,136)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	8,264	(74,398)	0	0	0	0	0	0	0	0	0	(66,134)	45

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE OWNER'S LIST ATTACHED				ST. CLAIR ESTATES	FREEBURG	REAL ESTATE
				LAND TRUST		RENTAL

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 132,000	ST. CLAIR ESTATES	100.00%	$	$ (132,000)	1
2	V	32	INTEREST EXPENSE		ST. CLAIR ESTATES	100.00%	24,188	24,188	2
3	V	30	DEPRECIATION		ST. CLAIR ESTATES	100.00%	33,661	33,661	3
4	V	32	INTEREST INCOME		ST. CLAIR ESTATES	100.00%	(1,720)	(1,720)	4
5	V	21	ALZHEIMER'S PROJECT CNCLD		ST. CLAIR ESTATES	100.00%	1,473	1,473	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 132,000			$ 57,602	$ * (74,398)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	LARRY RHUTASEL	CONSULTANT	ADM. CONSUL	6.90	NONE	2	5.00	ADM CONS	$ 5,400	17/3	1
2	JOHN SCHAUFLER	CONSULTANT	ADM. CONSUL	20.70	NONE	2	5.00	ADM CONS	1,200	17/3	2
3	CAROLYN STUMPF	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fee	1,200	18/3	3
4	JOHN SCHAUFLER	DIRECTOR	board member	20.70	NONE	N/A	N/A	director fee	1,200	18/3	4
5	LARRY RHUTASEL	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fee	1,200	18/3	5
6	FRANK HEILIGENSTEIN	DIRECTOR	board member	3.44	NONE	N/A	N/A	director fee	1,000	18/3	6
7	WAYNE HEBERER	DIRECTOR	board member	6.90	NONE	N/A	N/A	director fee	600	18/3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 11,800		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	UNION PLANTERS BANK		X	REAL ESTATE MORTGAGE	$10,151.00	08/28/97	$ 1,050,307	$ 573,620	08/28/05	0.0375	$ 24,188	1
2	(NOW REGIONS BANK)											2
3												3
4												4
5												5
	Working Capital											
6	LOAN FROM ST. CLAIR		X	OPERATIONS	N/A	N/A		45,000	NONE	variable	1,712	6
7												7
8												8
9	TOTAL Facility Related				$10,151.00		$ 1,050,307	$ 618,620			$ 25,900	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,050,307	$ 618,620			$ 25,900	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number FREEBURG CARE CENTER **#** 0025098 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	38,126	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	40,552	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,426	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	40,550	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	42,976	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	40,284	8
	2000	36,906	9
	2001	39,594	10
	2002	38,345	11
	2003	40,552	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME FREEBURG CARE CENTER COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0025098

CONTACT PERSON REGARDING THIS REPORT ROGER BAGLEY

TELEPHONE (618)549-8331 FAX #: (618)549-0133

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-29.0-400-040	LOT/SEC-29-SUBL/TWP-1S-BLK	$ 40,528.00	$ 40,528.00
2.	14-29.0-400-038	LOT/SEC-29-SUBL/TWP-1S-BLK	$ 24.42	$ 24.42
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 40,552.42	$ 40,552.42

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,405 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	150,000	1979	$ 22,480	1
2					2
3	TOTALS	150,000		$ 22,480	3

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1979	1979	$ 1,174,206	$	30	$ 39,140	$ 39,140	$ 1,009,486	4
5	10		1985	1985	227,899		30	7,597	7,597	148,141	5
6			1985	1986	3,116		30	104	104	1,924	6
7			1989	1989	2,110		27	78	78	1,248	7
8	10		1998	1997	411,348		39.5	10,415	10,415	78,061	8
	Improvement Type**										
9	PARKING LOT TITLE INSURANCE			1981	7,109		30	237	237	5,668	9
10	SIDEWALK			1983	908		20			908	10
11	LAUNDRY RENOVATION			1983	3,303		25	132	132	2,838	11
12	STORAGE BUILDING			1983	6,690		20			6,690	12
13	WINDOW REPLACEMENT			1983	967		30	32	32	688	13
14	KITCHEN RENOVATIONS			1983	734		25	29	29	624	14
15	VENTILATION SYSTEM/INSULATION			1984	1,132		10			1,132	15
16	CONCRETE PAVING			1985	4,124		20	206	206	4,017	16
17	PARKING LOT			1986	2,518		10			2,518	17
18	STORAGE SHED			1987	10,213		15			10,213	18
19	DRIVEWAY			1988	3,990		15			3,990	19
20	DRIVEWAY			1989	1,465	44	15	44		1,465	20
21	ENTRY SIGN			1990	2,890	193	15	193		2,798	21
22	PARKING LOT			1990	11,951	797	20	598	(199)	8,671	22
23	SEWER			1990	17,548	1,170	25	702	(468)	10,179	23
24	LIGHTS			1990	1,140	76	10		(76)	1,140	24
25	HEAT PUMPS / COMPRESSOR			1990	2,527	168	8		(168)	2,527	25
26	SEWER REPAIRS / DRIVEWAY REPAIRS / PLUMBING			1991	4,471	298	15	298		4,024	26
27	ROOFTOP AIR CONDITIONER			1991	4,600		8			4,600	27
28	FRONT OFFICE REMODELING / DRIVEWAY REPAIRS			1992	10,838	723	15	723		9,038	28
29	CARPET			1992	14,036		5			14,036	29
30	PARKING LOT & DRIVEWAY			1993	14,900	993	15	993		11,420	30
31	FENCE / PARKING LOT & DRIVEWAY			1994	6,672	445	15	445		4,673	31
32	CEILING TILE			1994	1,310		5			1,310	32
33	LANDSCAPING			1996	1,499	150	10	150		1,275	33
34	WATER HEATER			1996	3,426	228	15	228		1,938	34
35	5 TON CONDENSING UNIT			1996	1,195	120	10	120		1,020	35
36	WATER LINE & GAS LINE FOR ADDITION			1997	633	63	10	63		473	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	AIR COMPRESSOR FOR FIRE SYSTEM	1997	$ 1,244	$ 83	10	$ 124	$ 41	$ 930	37
38	CERAMIC TILE & LABOR FOR SHOWERS	1997	5,795	386	10	386		2,895	38
39	ROCK & ROAD GRADING	1997	502		15			502	39
40	REMOVE DRIVEWAY & RECONCRETE	1997	4,274	285	5	285		2,137	40
41	LABOR & MATERIAL TO BUILD WALL IN LAUNDRY ROOM	1997	503	50	15	50		375	41
42	TELEPHONE SYSTEM	1997	4,640	207	10	464	257	3,480	42
43	8 G E HEAT / COOL UNITS	1997	7,624	341	10	762	421	5,715	43
44	cabinets, countertops, & labor for new nurses station and	1998	6,073	405	15	405		2,632	44
45	gutting of old								45
46	expanded care plan office adding countertop & windows	1998	6,952	463	15	463		3,010	46
47	FIRE ALARM	1998	4,431	295	15	295		1,918	47
48	5 TON HEATING A/C UNIT ROOF TOP	1998	2,918	195	15	195		1,267	48
49	PHONE JACKS INSTALLED	1998	777	52	15	52		338	49
50	4 G E HEAT / COOL UNITS	1998	3,884		10	388	388	2,522	50
51	replaced ceiling tile & constructed new storage cabinets in	1999	4,951	495	10	495		2,723	51
52	activity room								52
53	ROOF TOP FAN	1999	866	58	15	58		319	53
54	WORK ON ROOFTOP A/C UNIT	1999	3,170	226	14	226		1,243	54
55	NEW ROOF ON WINGS A,B,&C	1999	16,397		10	1,640	1,640	9,020	55
56	WALLPAPER IN DINING ROOM	2000	1,255	251	5	251		1,130	56
57	gutted bathroom installed windows & worktop to convert to	2000	2,374	237	10	237		1,067	57
58	DON office								58
59	finish DON office-mudd, sand, and paint room, Set cabinets	2001	2,194	219	10	219		767	59
60	& build shelves, Put carpet & cove base down & handrail up								60
61	remove & repair concrete entrance sidewalk	2001	1,750	117	15	117		409	61
62	remove old shower on d-hall and put in new shower walls	2001	2,097	210	10	210		735	62
63	and mudd, sand, and paint to seal plaster around shower								63
64	tear out wall between secretary and bookkeeper office	2003	6,638	664	10	664		996	64
65	and build countertops and workspace, new carpet, paint etc.								65
66	BUILD UP ROOF SECTION	2004	8,072	404	10	404		404	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,060,849	$ 11,111		$ 70,917	$ 59,806	$ 1,405,267	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 156,885	$ 6,232	$ 17,283	$ 11,051	various	$ 100,713	71
72	Current Year Purchases	12,350	12,350	767	(11,583)	various	767	72
73	Fully Depreciated Assets	339,794				various	339,794	73
74								74
75	TOTALS	$ 509,029	$ 18,582	$ 18,050	$ (532)		$ 441,274	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,592,358	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 29,693	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 88,967	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 59,274	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,846,541	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 38 Description: CARPET CLEANER
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   we only hire trained aides

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39/3	hrs	$	427	$ 27,149	$	427	$ 27,149	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		64	5,660		64	5,660	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3;39/2	hrs		592	37,688	396	592	38,084	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	oxygen,tubefeeding, med supplies, iv's Other (specify): lab, x-ray	39/2 39/3				8,024	117,611		125,635	13
14	TOTAL			$	1,083	$ 78,521	$ 118,007	1,083	$ 196,528	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number FREEBURG CARE CENTER **#** 0025098 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2004 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,769	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	513,571		3
4	Supply Inventory (priced at COST)	3,055		4
5	Short-Term Investments	36,859		5
6	Prepaid Insurance	52,761		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 616,015	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	180,209		15
16	Equipment, at Historical Cost	341,585		16
17	Accumulated Depreciation (book methods)	(456,922)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 64,872	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 680,887	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 84,862	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	335,000		29
30	Accrued Salaries Payable	35,964		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,692		31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,550		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	401K LIABILITY	10,739		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 527,807	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 527,807	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 153,080	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 680,887	$	48

***(See instructions.)**

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 147,301	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 147,301	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,779	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 5,779	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 153,080	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,925,052	1
2	Discounts and Allowances for all Levels	88,704	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,013,756	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	131,620	6
7	Oxygen	14,707	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 146,327	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,036	19
20	Radiology and X-Ray	875	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,911	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	103	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 103	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,166,097	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	576,073	31
32	Health Care	1,506,156	32
33	General Administration	596,585	33
	B. Capital Expense		
34	Ownership	220,194	34
	C. Ancillary Expense		
35	Special Cost Centers	196,528	35
36	Provider Participation Fee	64,782	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,160,318	40
41	**Income before Income Taxes (line 30 minus line 40)****	5,779	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 5,779	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.** Il repl. Tax deducted on fed tax return

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,118	3,470	$ 74,335	$ 21.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,718	3,832	73,265	19.12	3
4	Licensed Practical Nurses	18,653	20,004	322,500	16.12	4
5	Nurse Aides & Orderlies	58,704	63,450	654,199	10.31	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	205	245	1,762	7.19	8
9	Activity Director	3,550	3,927	33,066	8.42	9
10	Activity Assistants					10
11	Social Service Workers	2,104	2,336	25,909	11.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,906	2,184	28,872	13.22	14
15	Cook Helpers/Assistants	14,047	15,287	117,967	7.72	15
16	Dishwashers					16
17	Maintenance Workers	1,908	2,149	28,718	13.36	17
18	Housekeepers	10,207	11,055	84,409	7.64	18
19	Laundry	6,020	6,260	49,378	7.89	19
20	Administrator	2,016	2,160	62,570	28.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,815	4,223	48,200	11.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) WARD CLERK	1,464	1,581	16,827	10.64	33
34	TOTAL (lines 1 - 33)	131,435	142,163	$ 1,621,977 *	$ 11.41	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	150	$ 7,187	1/3	35
36	Medical Director		3,000	9/3	36
37	Medical Records Consultant	19	740	10/3	37
38	Nurse Consultant		41	10/3	38
39	Pharmacist Consultant	36	825	10/3	39
40	Physical Therapy Consultant	7	428	10A/3	40
41	Occupational Therapy Consultant	1	62	10A/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1	62	10A/3	43
44	Activity Consultant	42	1,340	11/3	44
45	Social Service Consultant	42	1,340	12/3	45
46	Other(specify) ADMINISTRATIVE		6,600	17/3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	298	$ 21,625		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	5,335	153,947	10/3	51
52	Nurse Aides	6,500	117,707	10/3	52
53	TOTAL (lines 50 - 52)	11,835	$ 271,654		53

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOHN HUELSKAMP	ADMINISTRATOR	0	$ 62,570
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 62,570

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANTS	$ 6,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 6,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
JAMESTOWN MGMT	MANAGEMENT	$ 112,996
ADP	PAYROLL SERVICES	909
RICHARD BRESLIN	TAX RETURN PREP.	585
PUTNAM FIDUCIARY	401K SERVICES	2,385
MIKRON	COMPUTER SERVICES	720
FREESTONE COMPUTING	COMPUTER SERVICES	9
M. D. SERVICES	COMPUTER SERVICES	360
LECHIEN & LECHIEN	LEGAL SERVICES	668
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 118,632

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 108,517
Unemployment Compensation Insurance	16,141
FICA Taxes	124,081
Employee Health Insurance	10,501
Employee Meals	509
Illinois Municipal Retirement Fund (IMRF)*	
401K CONTRIBUTION	8,930
HEP B, TB, AND FLU VACCINES	37
EMPLOYEE PARTIES, AWARDS, GIFTS, ETC.	5,292
TOTAL (agree to Schedule V, line 22, col.8)	$ 274,008

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 760
Advertising: Employee Recruitment	2,313
Health Care Worker Background Check	
(Indicate # of checks performed 32)	512
other adv(3150)ch of comm(25)(elim)	3,175
city business license(10) ltc don(30)	40
INHAA(100)SUBSC(412)CLIA LAB(150)	662
SEC OF STATE(100) SAM'S CLUB(120)	220
NAGNA	138
ELIM CHAMBER OF COMMERCE	(25)
Less: Public Relations Expense	( )
Non-allowable advertising	(3,150)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,645

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,125
Seminar Expense	864
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,989

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number FREEBURG CARE CENTER # 0025098 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING	2002	$ 2,141	3	$	$ 357	$ 714	$ 714	$ 356	$	$	$	$
2	PAINTING	2003	1,616	3			269	539	539	269			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,757		$	$ 357	$ 983	$ 1,253	$ 895	$ 269	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **8.9 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **64,782**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **509** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

FREEBURG CARE CENER
SCHEDULE OF RECLASSIFICATIONS PAGES 3&4 COLUMN 5
12/31/2004
ID # 0025098

LINE#	ACCOUNT TITLE DESCRIPTION	DEBIT	CREDIT
2	FOOD PURCHASES	5320	
10	NURSING & MEDICAL RECORDS		5320
	RECL FOOD SUPPLEMENTS		
22	EMPLOYEE BENEFITS	509	
2	FOOD PURCHASES		509
	RECL EMPLOYEE MEALS		